Fall Reduction

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ELDA
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Defining The Problem

* Triggering 95% on QM's for Falls
* Increased risk for resident injuries from falls
* Increased cost for residents and facility related to falls
* Improved resident safety

Team Members Involved

* C.N.A's: from each shift
* Nurses: from each shift
* Housekeeping
* Therapy
* MDS coordinator
* Nursing Administration
* Dietary
* Maintenance
* People Development

Establishing the Goal

* Reduction of Falls by 20% : focusing on the residents with reoccurring falls.
* Average monthly falls since January was 21.
* The current new goal is 17 and under.

The focus was placed on specific residents with a high number of falls.

Emphasis to be placed on keeping the resident engaged in activities, offering assistance to the bathroom at scheduled times.

Investigative Tools

Unusual Occurrence Summary
Team Member Fall evaluation tool
Fall Huddles
Reenactments
Open discussion with witnesses of the fall
Fall tracking tool
Pharmacy evaluations
Therapy Screens

Monthly Fall Meetings

Agenda:

1.Discuss minutes from previous meeting: address any unresolved issue.

2.Discuss falls for the current month

3.Reinact any questionable falls

4.Discuss environmental factors within the facility

5. Discuss specific residents that are at risk for falls.

Fall Statistics

* September Stats:

  21 total falls

  Thursdays had the most Falls

  6-2 shift had the most falls

  High fall times: 10:00am-11:59am & 1:30pm-2:59 pm. 5:00pm-7:59pm and 1:00am-4:49am

  6 falls resulted in injury:

  1 skin tear

  3 contusions

Fall stats cont.

1 abrasion
1 other: pain
1 resident required treatment outside the facility

Post Fall evaluations:
47.62% had a history of falls
14.29% had an underlying chronic medical problem.
9.52% had medications prescribed that could

Fall stats cont.

Predispose the resident to falls.

33.33% had issues with functional status

19.05% had sensory issues: vision issues being the highest.

4.76% had impaired cognition

14.29% had environmental issues that contributed to the fall.

Clinical Considerations

Correlation of increased falls related to the use of antipsychotic medications.

Correlation of increased falls with residents that currently have pressure alarms

As a facility we are currently working to reduce our antipsychotic medication use. Since August we have reduced by 8.2%.

Moving Forward

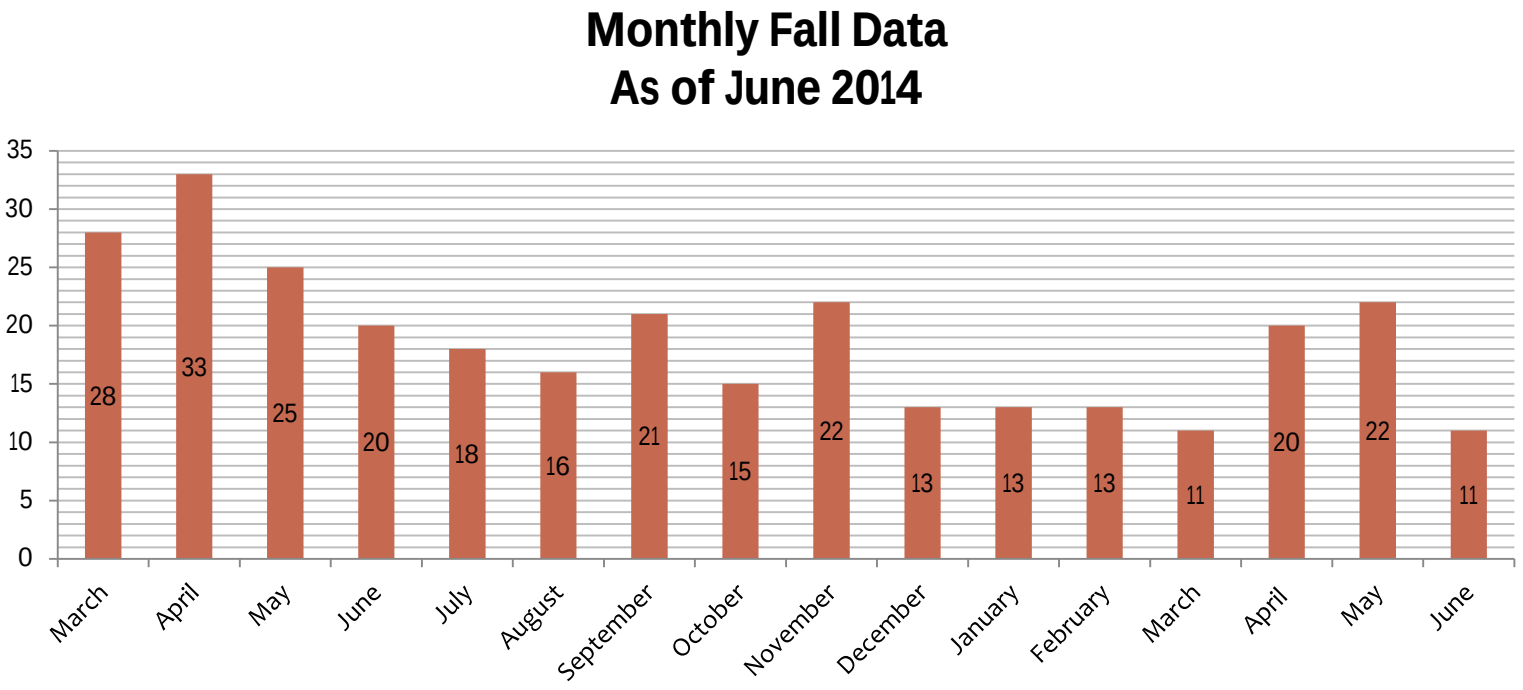
* Continue monthly fall meetings
* Continue to identify strategies/solutions to achieve current goals.
* Staff to provide feedback to members of the fall team. Continue to improve communication for the common goal.
* Share success with the facility team members
* Share information/ goal achievement with the team during monthly team meetings.

Fall Awareness

Cont.

* Continue to encourage input from all staff regarding this process.

Updated Data



Updated Information

* Recognized we still had work to do:

addition of Admission Medication Regimen Reviews (aMRR) on all new admissions. Allows the consulting Pharmacist to review ALL medications on admission for potential opportunities.

Specific medications being addressed:

Antipsychotics

Antidepressants

Anticholinergics

Antidepressants: SSRI's

Cont.

* Assessment completed on admission to reduce unnecessary medication use and communication with the prescriber. Observe closely for PIM's potentially inappropriate medications.
* Close attention to Beers Criteria

Updated Information cont.

A Geriatric Risk assessment is done as a screening tool to provide opportunities for improvement.

Continuing with Fall Huddles and a Facility Team Review involving a Multidisciplinary Team approach in finding the root cause of the fall.

Assessing Vitamin D levels and adding supplementation if levels are low.

Summary

As a Facility we have adapted the concept of being Proactive vs Reactive.

Have used the 5 whys during our investigative process:

What?

Who?

When?

Where?

Why?

Cont.

Reinforcing that a Multidisciplinary approach is the best approach.

Implementing the Stop and Watch tool to be used by all team members.

Our company made a huge investment and incorporated a new approach to dementia training "**Buddies Forever**". Understanding that by having consistent staff and properly trained we saw reductions in our numbers of falls.

Thank you

* Questions?